

REVIEW ARTICLE

# School Avoidance From the Point of View of Child and Adolescent Psychiatry

Symptomatology, Development, Course, and Treatment

Martin Knollmann, Susanne Knoll, Volker Reissner, Jana Metzelaars, Johannes Hebebrand

## SUMMARY

**Background:** A considerable percentage of children and adolescents who avoid school have mental illnesses. This article reviews the typical manifestations, classification, development, course, and treatment of school-avoiding behavior.

**Methods:** Based on a selective review of recent literature, we present findings on the psychopathologically relevant features of school-avoiding children and adolescents, including psychiatric diagnoses, developmental, family-related, and psychological test variables. The emphasis is placed on our own studies of the subject.

**Results:** Although the evidence from the studies that have been performed to date is not definitive, the available findings show that school avoidance is associated with poor mental health and with unfavorable consequences onward into adulthood. Its causes include a number of individual and social stressors that place excessive demands on the affected children and adolescents and lead them to avoid school as a coping attempt.

**Conclusions:** Many preventive and therapeutic interventions are now available, but the existing measures need to be better coordinated, and more effort needs to be directed to the early recognition and treatment of school-avoiding behavior. Physicians should consider the possibility of mental illness. Rather than writing sick notes or prescribing mother-child treatments at health resorts, which rather tend to sustain the problem, they should refer patients promptly to a child and adolescent psychiatrist.

Up to 60% of students at secondary schools in Germany report having avoided attending school for several hours or even a whole day over the course of their schooling so far (1). However, school avoidance gains importance in terms of child and adolescent psychiatry only when it occurs to a notably greater degree and is accompanied by psychiatric symptoms. This article aims to review the findings on the psychopathologically relevant features of children and adolescents who avoid school. In view of the available recent review articles (2–6, e1) and the scarcity of available data in Germany, the emphasis lies on the more recent, mostly English language, literature and the results of two of the authors' own recent studies (7, 8).

## Symptoms, classification, and prevalence

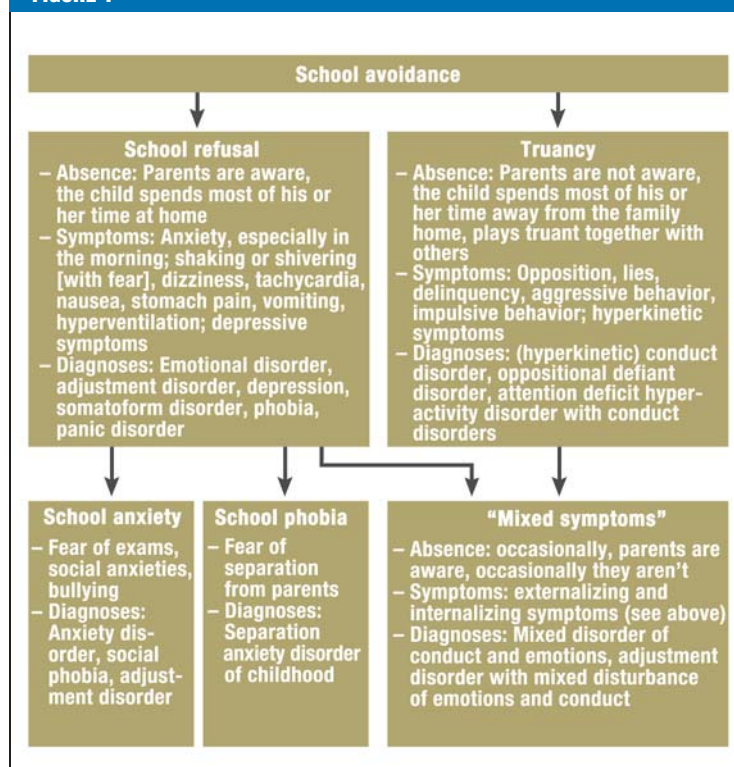
The term “school avoidance” (e2) is used in this article to describe absences from school that are associated with psychiatric symptoms. The literature further differentiates between truancy (deliberately not attending school) without anxiety symptoms and anxiety related school refusal (*Figure 1*). The latter is further subcategorized into school related anxieties (test anxiety, social phobias) and separation anxiety (fear of being separated from a parent or loved carer) (*Figure 1*) (9). A close association is assumed between conduct disorders and truancy on the one hand, and on the other hand between school refusal and anxiety disorder and other emotional disorders (2). There are indications that school avoiders may have symptoms covering the entire range of child and adolescent psychiatric disorders (8) and that substantial overlaps exist between school refusers and truants (*Figure 1*). A study that is representative for the US (10) found a greater extent of conduct disorders than of emotional disorders in truants than in school refusers (and vice versa), but the highest rate of psychiatric disorders was seen in children with a mixture of truancy and school refusal. The frequency of psychiatric diagnoses differs depending on the type of sample under consideration (clinical sample: up to 90%, representative samples: up to 24.5 %) (2).

It is difficult to estimate the prevalence of school avoiding behavior because different definitions and data collection methods are in use (1, 2). Most authors assume a proportion of 5% to 10% of regular school

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FIGURE 1



Classification of school avoidance

avoiders in Germany, whose school absences reach “a substantial extent” (3, 11, 12). School avoidance is notably more common in adolescents than in children. Individual studies have shown that boys are affected more often than girls, at a ratio of 2:1 (2, 3). The highest rates of school avoidance are seen in secondary general schools (Hauptschulen) and schools catering for special needs (Sonderschulen) (11), but no school type is exempt from the phenomenon. The current National Report on Education shows that the number of school leavers without a final graduation certificate in Germany (in 2006: about 76 000; i.e. about 8% of every year) is still high compared with the rest of Europe (13); a higher proportion of these youngsters may be assumed to avoid school. Although proportionally more students from (im)migrant families leave school without graduating (13), no clear indications exist that school avoidance prior to school drop out is more common in these students (1). In interpreting studies with positive findings in this regard (e3, e4), possible confounding by socioeconomic status should be considered (6, e5, e6).

### Course

Most studies have shown an increase in school refusal between the 5th and 6th as well as the 10th and 11th year of life. By contrast, truancy typically occurs for the first time at the age of about 11 and increases between the 13th and 17th years of life (2, 10, 11).

Whereas anxiety related school refusal dominates during childhood, the range of disorders widens substantially with the onset of adolescence (5). Truancy is prognostically associated with an increased risk for social problems, such as:

- School failure (odds ratio [OR]=4.6)
- Unemployment (OR=2.4)
- Drug misuse (OR=2.2)
- Delinquency (OR=4.0) (e7).

Anxiety related school refusal is primarily associated with the continued existence or development of psychiatric disorders (OR=3.1) (14).

Prognostically favorable factors include:

- Acute onset of symptoms
- Younger age at symptom onset
- Less time spent absent from school
- Early diagnosis and treatment
- Lower psychiatric morbidity
- Lesser extent of avoidance (15).

Conversely, the risk of symptoms becoming chronic increases when help is not given rapidly and the so-called protective factors are lacking (Box 1).

The unfavorable effects of school avoidance on children’s or adolescents’ further development are obvious: School attendance and subsequent employment are important to ensure not only their future financial security but also their participation in social life and activities, and to establish social contacts. School and employment further provide a useful and beneficial structure for people’s daily lives. In spite of these obvious connections, studies of youth unemployment have only rarely investigated the topic of school avoidance in the subjects’ histories (16). In the context of the collaboration project “SUPPORT 25”, unemployed people younger than 25 in whom psychiatric disorders are suspected are offered psychiatric diagnosis and advice at short notice (7). 97.6% of those examined (n=165, 96 female; mean age=21) had at least a psychiatric Axis I disorder according to ICD-10. School avoiders—individuals who during their school years remained absent from lessons for at least a month (30% of the participants)—significantly more often left school without graduating and also sought psychiatric help before their 18th year of life more often. The trend was also for school avoiders to seek psychiatric care more often once they had reached legal age and they more often displayed conduct disorders as per a retrospective lifetime diagnosis. Further, school avoiders responded more pessimistically to the question on the likelihood of finding a job and starting gainful employment within the coming 2 years.

### Development

School refusal should not be reduced to medical or psychological aspects but is always embedded in complex social conditions. The available findings give credence to the assumption that factors such as parenting style, relative poverty, living in socially disadvantaged areas, attitudes to schooling, and the school system itself all have an influence (2, 6, 10, 17). Psychological models

of the development of school avoidance emphasize interactions between family related, school related, and individual variables. For truancy, parallels have been shown with etiological models of conduct disorder (e8), for school refusal the parallels were with models of the development of anxiety disorders (9). At the same time, there are many common factors (*Figure 2*), which will be explained on the basis of relevant studies and the authors' own findings from a sample of 89 patients (42 female; mean age=14.4). These patients attended a child and adolescent psychiatric outpatient clinic specializing in school avoidance/refusal (8). Accordingly, school avoidance should be interpreted as a reaction to being overchallenged in the school, peer, and family contexts, which develops on a background of individual vulnerabilities.

### School context and peer context

Of all patients in the authors' own sample, 11.2% attended a school for children with special needs (Sonderschule), 34.8% secondary general school (Hauptschule), and 23.6% comprehensive school (Gesamtschule). 51.6% had repeated a class at least once. 61.8% had switched to lower-grade schools (with the exception of one case, where the student moved to a higher-grade school). These data, which significantly differ from those of representative non-clinical samples (8), confirm other findings according to which school avoiders typically have a school career that is characterized by failures (1, 15, 17). Further, the peer-relationships of school avoiders are often characterized by conflict (6, 10, 17). Truants often have contact to deviant youth groups (18), whereas school refusers often have problems with social integration. In the authors' own sample, 22.5% of patients describe themselves as victims of bullying; 33.7% were categorized as altogether poorly socially integrated. These data are roughly consistent with those of international studies (6, 19). Some studies have pointed out that, further to experiences of violence or social exclusion, another factor contributing to school avoidance may also be the subjective experience of the school atmosphere as bad (6, 17, e9). Factors that may play a part in this context include:

- School size and class size
- The relationships between teachers, principals, and students
- Cooperation between school and parents
- Teachers' monitoring of students' absence (6, 17, e3).

### Family context

The proportion of children who were affected by their parents' separation in the authors' own sample was significantly higher (60.5%) than in representative samples (about 19%) (e10). The frequency of severe physical (29.2%) and mental (14.6%) parental illness (e11) in our sample also underlines the importance of family stresses. In comparable studies with populations of school avoiding patients from specialized child and

TABLE

Frequency of Axis I initial diagnoses according to ICD-10 (n=89 patients)

Diagnosis Axis I ICD-10	Frequency (%)
Other childhood emotional disorder	28 (31.5%)
Adjustment disorder with depressive reaction	7 (7.9%)
Adjustment disorder with anxiety and depression	2 (2.2%)
Separation anxiety disorder of childhood	3 (3.4%)
Post-traumatic stress disorder	1 (1.1%)
Social phobia	3 (3.4%)
Somatoform disorder	2 (2.2%)
Recurrent depressive episode	1 (1.1%)
Moderate depressive episode	1 (1.1%)
Socialized conduct disorder	11 (12.4%)
Hyperkinetic conduct disorder	3 (3.4%)
Adjustment disorder with disturbance of conduct	5 (5.6%)
Unsocialized conduct disorder	1 (1.1%)
Conduct disorder confined to family context	1 (1.1%)
Other conduct disorders	5 (5.6%)
Depressive conduct disorder	4 (4.5%)
Other mixed disorders of conduct and emotions	7 (7.9%)
Adjustment disorder with mixed disturbance of emotions and conduct	4 (4.5%)

Source: (8)

adolescent psychiatric outpatient clinics, family stresses figured even more prominently (8, 19). Further familial risk factors include:

- Low socioeconomic status of the parents
- Unemployment
- Frequent relocations
- Low parental control
- Social isolation of the family
- Complex/convoluted or emotionally distant family relationships
- Frequent family conflicts (5, 10, 11, 17, 19, e12).

In truanting children, the dominating stress factors are associated with low socioeconomic status, whereas school refusers tend to have a higher proportion of mentally ill parents (3, 10). Generally, school avoiders seem to be exposed to more stressful life events (20) than others.

### Individual features

39.1% of the authors' own patients had a lower than average IQ (<85), a significant difference to the proportion that might be expected on the basis of the reference norm (13.6%). Although other studies have hinted at an association merely between truancy and low intelligence (17), many school avoiders have reported problems with school performance before they started avoiding school (19). This indicates potential cognitive

**BOX 1**

### Case report of a female school refuser

**Reason for presentation:** A 14 year old female patient consulted a special mobile child and adolescent psychiatric service at a secondary general school (Hauptschule) for several problems: irregular school attendance (she missed roughly every other day, her performance had suffered, she reported performance anxieties), which the patient and her mother explained with strong somatization (nausea, vomiting, raised temperature, breathlessness without a physical cause), disturbed sleep, and bullying at school. The symptoms were reported to have started in the girl's 5th year at school.

**Family history:** Three close relatives had died within a year, including the girl's father; the mother became severely ill; the father had been an alcoholic and had been violent; the mother has had a new partner for a short while; several adult half-siblings on both the mother's and the father's side

**Patient's own history:** The mother's pregnancy was noticed only in the 6th month of gestation; the birth was uneventful; early feeding disorder; developmental milestones normal; from the age of 2 1/2 years the patient had visited a day nursery and integrated well; started school at 6 years of age, performance good to moderate; a move into a different town necessitated a change in school; at the new school the patient was often picked on; another house move and change in school owing to the mother's illness; 2nd year repeated; a third relocation into a new town, 3rd and 4th years attended at a new school; bullied by fellow students; move to secondary general school, poor social integration, bullying, start of school refusal; in 2008 the family moved to the mother's new partner's home and the patient changed school again (secondary general school), currently in her 7th year

**Diagnosis from psychological testing:** Average IQ, self assessment (Youth Self Report, YSR) noticeable with regard to physical complaints, assessment by her mother (Child Behavior Checklist, CBCL) noticeable with regard to physical complaints, anxiety/depression, social problems, aggressive behavior, anxiety and depression questionnaire normal.

**Suspected diagnoses:** Somatoform disorder (F45.0V); specific phobic disorder (F40.2V).

**Recommendation:** Inpatient admission for more thorough diagnostic evaluation, initiating inpatient or outpatient psychotherapeutic treatment

overchallenges owing to misplacement in the wrong type of school (17); in individual cases, above average intelligence should be considered (e13, e14). The authors' sample also yielded indications from psychological testing that attention deficit disorders may contribute to the lack of success at school especially in truants; other studies have found that specific developmental disorders of scholastic skills contribute to the development of school avoidance (21).

Pre-existing relevant child and adolescent psychiatric disorders may be assumed to contribute substantially to the individual factors even before a child starts to avoid school (*Figure 2*). In their histories, 20.2% of patients in the authors' sample had internalizing symptoms and 23.6% had externalizing symptoms before starting to avoid school (8). Recent studies have shown that physical disorders such as asthma (6, e15) or obesity (e16–e18) are associated with absenteeism.

### Diagnosis and treatment

The most important treatment objective in school avoidance is the resumption of school attendance. Doctor's sickness certificates for any psychosomatic complaints (*Figure 1*) are contraindicated because they increase school avoidance (by legitimizing the absence) and thus contribute to making it a chronic problem.

Pediatricians and primary care physicians should be familiar with the relevant symptoms (*Box 2*). The main

diagnostic clue is the occurrence of symptoms in the morning or even on the preceding evening and their absence at weekends or during holidays. In individual cases, parents changed their doctors often in order to be able to obtain repeated sick notes. It also should be borne in mind that conducting invasive, time-consuming, and costly physical diagnostic tests without including psychological factors in the diagnostic considerations bears the risk of chronification of the problem.

In child and adolescent psychiatry, the diagnosis includes—in addition to an extensive exploration of the child and its parents/carers—a psychological test for possible intellectual underchallenge or overchallenge and specific developmental disorders of scholastic skills. Questionnaire methods and structured clinical interviews are used to assess the key symptoms (21, e19) and to capture comorbid disorders. Kearney (22, e20, e21) distinguished between 4 functions of school avoidance:

- Attention seeking behavior/separation anxiety
- Avoidance of negative affect
- Positive reinforcement outside school
- Avoidance of exams and socially stressful situations.

These points should be captured in a questionnaire (e21, e22) and used as supporting information in treatment selection.

Therapy includes child centered, school centered, and family centered methods to reduce anxiety related



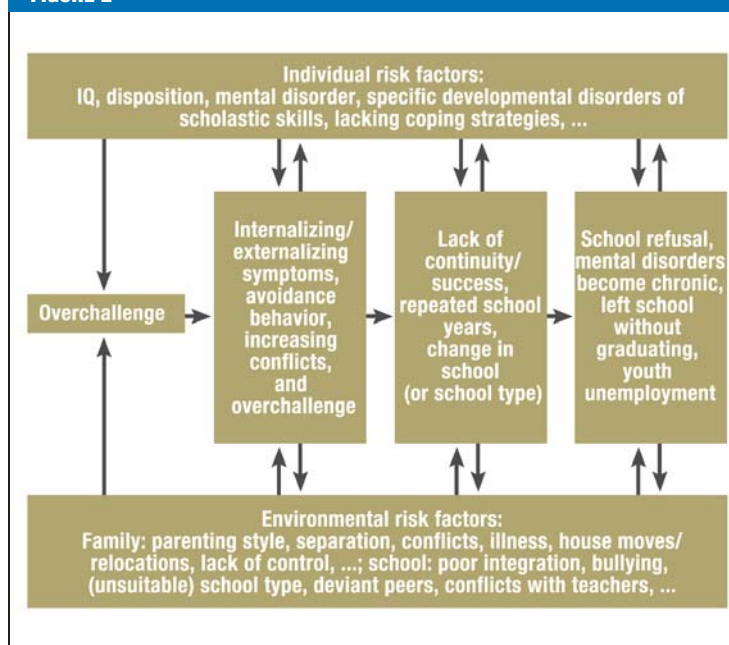
avoidance behavior (23, e23, e24). Several studies have shown the efficacy of cognitive behavioral therapies—also in combination with antidepressant drug treatment (imipramine) (3, 6, e25). To date, however, only few randomized, controlled evaluation studies (evidence level Ib) have been conducted; superiority to other treatments and increased efficacy if the parents are included has not been consistently shown (3, e26–e28). For the treatment of truancy which is associated with dissociative behaviour, controlled evaluation studies are lacking to date (6). In view of the often overlapping internalizing and externalizing symptoms, Kearney et al. (e29) recommend integrated treatment of all school avoiders, which should be oriented to the functional profile of the school avoiding behavior.

Especially in chronic cases, outpatient treatment is often not sufficient. In 20.2% of patients in the authors' own sample, inpatient treatment or a combination of in and outpatient treatment was recommended (8). A recent evaluation study has shown good effects 9 months after inpatient treatment had been concluded (e30). Follow-up studies over a longer time period, however, have shown that at least one third of school avoiding patients display mental problems later in life (3, 6, 14, 24, e31–e33). Exclusively psychiatric therapy is thus usually insufficient (6). For the individual case, a support system should be established that should include school, child and youth services, and pediatricians and primary care physicians. In recent years, a multitude of such model projects has been implemented (e34). In 2006, the German federal government initiated the program "Schulverweigerung – Die 2. Chance [School Avoidance—A Second Chance]" (25), in whose context coordination posts were set up in more than 150 sites. Case managers in those sites establish contact with school avoiders; the primary objective is reintegration into school. If this is unrealistic then those affected are given the option of graduating outside the regular school system. These projects have not been systematically evaluated to date.

## Conclusions and outlook

The large number of adolescents who leave school without graduating underlines the need for political action. The symptoms of school avoidance have to be taken very seriously in this context. The school system is confronted with the challenge to identify such students rapidly and initiate measures for their reintegration. In order to execute this important function properly, schools need support. The authors think it would be ideal for affected children and adolescents and their parents to be able to present to a team as early as possible—with the team consisting of an independent teacher, a social worker, and a child and adolescent psychiatrist. A task force of this kind could develop a concept for reintegrating the patient into school while considering the interdisciplinary diagnosis, and it could supervise its implementation. Bearing in mind the high financial follow-on costs of school avoidance, the expense of such measures seems more than justified.

FIGURE 2



Pathogenesis of school avoiding behavior

## BOX 2

### Reasons for presenting to a doctor and findings from the histories of patients with anxiety related school avoidance

#### Reasons for presenting to a doctor

Continuing physical symptoms that necessitate absence from school or occur in school: pallor, dizziness, nausea, vomiting, headache, stomach pains, chest pains, joint pains, backache, loss of appetite, diarrhea, need to urinate frequently. Onset of symptoms is often gradual without any definite reasons; occasionally abrupt onset of symptoms

#### Medical history and findings

**Complaints occur at certain times:** in the morning, sometimes in the evening. They disappear or reduce in severity at weekends or during term breaks; parents may make a concerted effort to persuade their children to attend school; school attendance often most difficult after the weekend, less so on specific school days

**Family history:** May be positive for anxiety disorders, depressive disorders, somatoform and/or psychiatric disorders of the parents/carers. Family deaths? Relocations, other stressors?

**Patient's own history:** Separation anxiety in kindergarten or on starting school, problems with school performance, sometimes occurring comorbidly with somatoform disorder; changing school; family stressors, school or peer group; social isolation

**Psychological/psychiatric finding:** No pronounced antisocial behavior, occasionally symptoms of depression or anxiety

**Compliance:** Large differences between individuals and families in the extent to which they are willing to deal with the problem

This hypothesis should be tested and proved by means of relevant evaluations.

Physicians should be familiar with the physical symptoms and psychiatric disorders that are associated with anxiety related school avoidance (*Figure 1, Box 2*). If initial diagnostic testing for physical disorders does not yield any pathological findings or if the findings are unclear, then—rather than (or in parallel to) further time consuming and costly physical investigations (risk of the problem becoming chronic)—an initial exploration of psychiatric disorders should be undertaken (leading questions: see *Figure 1* and *Box 2*) and early referral to a child and adolescent psychiatrist should be instigated. Doctors' sickness certificates and prescription of "Mutter und Kind Kuren" (a medical service that is covered by the statutory health insurers and offers 3 weeks of residential care to mothers [and their children if these cannot be looked after at home]) increase the symptoms and are contraindicated. Child and adolescent psychiatrists are tasked with offering and establishing special consultations with short waiting times for school avoiders. The effectiveness of mobile consultations at schools and in institutions catering for young people should also be studied. Research is needed into the role of child and adolescent psychiatric disorders, psychosocial and school related risk factors in the development of school avoidance and its effects in the medium and long term.

#### Conflict of interest statement

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#### REFERENCES

1. Weiß B: Wer schwänzt wie häufig die Schule? Eine vergleichende Sekundäranalyse auf Grundlage von 12 deutschen Studien. In: Wagner M (ed.): Schulabsentismus. Soziologische Analysen zum Einfluss von Familie, Schule und Freundeskreis. Weinheim: Juventa 2007; 37–56.
2. Lehmkuhl U, Lehmkuhl G: Schulverweigerung – ein heterogenes Störungsbild. Bundesgesundheitsblatt für Gesundheitsforschung und Gesundheitsschutz 2004; 47: 890–5.
3. Jans T, Warnke A: Schulverweigerung. Monatsschrift Kinderheilkunde 2004; 152: 13002–12.
4. Kearney CA: School refusal behavior in youth: A functional approach to assessment and treatment. Washington, DC: American Psychological Association 2001.
5. King NJ, Bernstein GA: School refusal in children and adolescents: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry 2001; 40: 197–205.

#### KEY MESSAGES

- School avoiding behavior can be categorized into anxiety related school refusal and truancy (often accompanied by conduct disorders), but large overlaps exist between these two groups.
- The estimated prevalence of pronounced school avoidance is 5–10%. It is unclear thus far how many of those affected have psychological impairments; a high rate of clinically relevant symptoms have been found in clinical samples.
- School avoidance usually develops from different stress factors that accumulate in the family setting (for example, separation of the parents), in school (for example, overchallenge), and in the peer context (for example, bullying), which in turn aggravate existing weaknesses (for example, specific developmental disorders of scholastic skills)
- In view of the often chronic course of school avoidance, early diagnosis by child and adolescent psychiatrists is recommended. A referral should be made especially if school avoidance is accompanied by somatic complaints of unknown origin (for example, stomach pains, nausea, headaches, dizziness).
- A doctor's sickness certificate for psychosomatic complaints and a prescription for a period of residential care for mothers and children are usually inadvisable, since these measures increase school avoiding behavior. In many cases, child and adolescent psychiatric treatment on an outpatient or inpatient basis is indicated in order to reduce anxiety related avoidance behaviors.

6. Kearney CA: School absenteeism and school refusal behavior in youth: A contemporary review. Clinical Psychology Review 2008; 28: 451–71.
7. Rosien M, Reissner V, Hebebrand J: SUPPORT 25 – Jugendarbeitslosigkeit und seelische Gesundheit. Psychotherapie im Dialog 2008; 9: 311–2.
8. Knollmann M, Al-Mouhtasseb K, Hebebrand J: Schulverweigerung und psychische Störungen: Merkmale von Schulverweigernden Kindern und Jugendlichen und ihren Familien einer kinder- und jugendpsychiatrischen „Schulverweigererambulanz“. Praxis der Kinderpsychologie und Kinderpsychiatrie 2009; 58: 434–49.
9. Döpfner M, Walter D: Schulverweigerung. In: Steinhausen H C (ed.): Schule und psychische Störungen. Stuttgart: Kohlhammer 2006; 218–35.
10. Egger HL, Costello EJ, Angold A: School refusal and psychiatric disorders: a community study. Journal of the American Academy of Child and Adolescent Psychiatry 2003; 42: 797–807.
11. Wagner M, Dunkake I, Weiß B: Schulverweigerung. Empirische Analysen zum abweichenden Verhalten von Schülern. Kölner Zeitschrift für Soziologie und Sozialpsychiatrie 2004; 56: 457–89.
12. Schreiber-Kittl M, Schröpfer H: Abgeschrieben? Ergebnisse einer empirischen Untersuchung über Schulverweigerer. München: DJI 2002.
13. Autorengruppe Bildungsberichterstattung: Bildung in Deutschland 2008. Ein indikatorengestützter Bericht mit Analysen zu Übergängen im Anschluss an den Sekundarbereich I. Bielefeld: Bertelsmann 2008.

14. Flakierska N, Lindstrom M, Gillberg C: School refusal: A 15–20-year follow-up study of 35 Swedish urban children. *Comprehensive Psychiatry* 1997; 38: 17–22.
15. Lehmkuhl G, Flechtner H, Lehmkuhl U: Schulverweigerung: Klassifikation, Entwicklungspsychopathologie, Prognose und therapeutische Ansätze. *Praxis der Kinderpsychologie und Kinderpsychiatrie* 2003; 52: 371–86.
16. Woodward LJ, Fergusson DM: Childhood peer relationship problems and later risks of educational under-achievement and unemployment. *Journal of Child Psychology and Psychiatry* 2000; 41: 191–201.
17. Rickling H: Schulabsentismus als Forschungsgegenstand. Oldenburg: BIS-Verlag Universität Oldenburg 2003.
18. Samjeske K: Der Einfluss der Peers auf Schulverweigerung. In: Wagner M (ed.): Schulabsentismus. Soziologische Analysen zum Einfluss von Familie, Schule und Freundeskreis. Weinheim: Juventa 2007; 177–200.
19. McShane G, Walter G, Rey JM: Characteristics of adolescents with school refusal. *Australian and New Zealand Journal of Psychiatry* 2001; 35: 822–6.
20. Steinhausen HC, Müller N, Winkler-Metzge N: Frequency, stability and differentiation of self-reported school fear and truancy in a community sample. *Child and Adolescent Psychiatry and Mental Health* 2008; 2:17.
21. Naylor MW, Staskowski M, Kenney MC, King CA: Language disorders and learning disabilities in school-refusing adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 1994; 33: 1331–7.
22. Kearney CA: Forms and functions of school refusal behavior in youth: An empirical analysis of absenteeism severity. *Journal of Child Psychology and Psychiatry*, 2007; 48: 53–61.
23. Ihle W, Jahnke D, Esser G: Kognitiv-verhaltenstherapeutische Behandlungsansätze nicht dissozialer Schulverweigerung: Schulphobie und Schulangst. *Praxis der Kinderpsychologie und Kinderpsychiatrie* 2003; 52: 409–24.
24. McShane G, Walter G, Rey JM: Functional outcome of adolescents with 'school refusal'. *Clinical Child Psychology and Psychiatry* 2004; 9: 53–60.
25. [www.zweite-chance.eu/content/index\\_ger.html](http://www.zweite-chance.eu/content/index_ger.html) (Homepage): Die zweite Chance – Schulverweigerung.

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## E-REFERENCES

- e1. Heyne D, King NJ, Tonge BJ, Cooper H: School refusal: Epidemiology and management. *Paediatric Drugs* 2001; 3: 719–32.
- e2. Specht F: Schulvermeidendes Verhalten: Einführung in die Praxis von Differenzierung und Interventionsansätzen. *Bundesgesundheitsblatt Gesundheitsforschung und Gesundheitsschutz* 2004; 47: 31–5.
- e3. Guare RE, Cooper BS: *Truancy revisited: Students as school consumers*. Lanham, MD: Scarecrow 2003.
- e4. National Center for Education Statistics: *The condition of education 2006*. Washington, DC: US Department of Education 2006.
- e5. Population Council: *Poverty and school dropout in Pakistan*. Population Briefs 2006; 12: 5.
- e6. Zhang M: Links between school absenteeism and child poverty. *Pastoral Care in Education* 2003; 21: 10–7.
- e7. Farrington D: Later life outcomes of truants in the Cambridge study. In: Berg I, Nusen J (eds.): *Unwillingly to school*. London: Gaskell 1996; 96–116.
- e8. Scheithauer H, Petermann F: Aggression. In: F Petermann (ed.): *Lehrbuch der klinischen Kinderpsychologie und -psychotherapie*. Göttingen: Hogrefe 2000; 187–226.
- e9. Brookmeyer KA, Fanti KA, Henrich GC: Schools, parents, and youth violence: A multilevel, ecological analysis. *Journal of Clinical Child and Adolescent Psychology* 2006; 35, 504–14.
- e10. LBS-Initiative Junge Familie: *LBS Kinderbarometer 2007*. [www.lbs.de/die-lbs/initiative-junge-familie/veroeffentlichungen](http://www.lbs.de/die-lbs/initiative-junge-familie/veroeffentlichungen).
- e11. Matthejat F, Remschmidt H: The children of mentally ill parents [Kinder psychisch kranker Eltern]. *Dtsch Arztebl Int* 2008; 105(23): 413–8.
- e12. Lampert T, Kurth B-M: Socioeconomic status and health in children and adolescents—results of the German Health Interview and Examination Survey for Children and Adolescents (KiGGS) [Sozialer Status und Gesundheit von Kindern und Jugendlichen: Ergebnisse des Kinder- und Jugendgesundheits surveys (KiGGS)]. *Dtsch Arztebl Int* 2007; 104(43): A-2944–9.
- e13. Seely K: Gifted students at risk. In Silverman LK (ed.): *Counseling the gifted and talented*. Denver: Love 1993; 263–75.
- e14. Stamm M: Hochbegabt, aber Schulabbrecher? Eine empirische Studie zum Phänomen des Dropouts bei überdurchschnittlich begabten Jugendlichen in der Schweiz. *Zeitschrift für Sozialpädagogik* 2008; 3: 301–19.
- e15. Swahn MH, Bossarte RM: The associations between victimization, feeling unsafe, and asthma episodes among US high-school students. *American Journal of Public Health* 2006; 96: 802–4.
- e16. Taras H, Potts-Datema W: Obesity and student performance at school. *Journal of School Health* 2005; 75: 291–5.
- e17. Geier AB, Foster GD, Womble LG, et al.: The relationship between relative weight and school attendance among elementary school children. *Obesity* 2007; 15: 2157–61.
- e18. Kurth B-M, Ellert U: perceived or true obesity: which causes more suffering in adolescents? [Gefühltes oder tatsächliches Übergewicht: Worunter leiden Jugendliche mehr?] *Dtsch Arztebl Int* 2008; 105(23): 406–12.
- e19. Wiczerkowski W, Nickel H, Janowski A, Fittkau B, Rauer W: *Angstfragebogen für Schüler* (6. Aufl.). Göttingen: Hogrefe 1981.
- e20. Kearney CA: Identifying the function of school refusal behavior: A revision of the school refusal assessment scale. *Journal of Psychopathology and Behavioral Assessment* 2002; 24: 235–45.
- e21. Kearney CA: Confirmatory factor analysis of the school refusal assessment scale-revised: Child and parent versions. *Journal of Psychopathology and Behavioral Assessment* 2006; 28: 139–44.
- e22. Overmeyer S, Schmidt MH, Blanz B: Die Einschätzungsskala der Schulverweigerung (ESV) – modifizierte deutsche Fassung der School Refusal Assessment Scale (SRAS) nach Kearney und Silverman 1993. *Kindheit und Entwicklung* 1994; 3: 238–43.
- e23. Walter D, Boyraz M, Döpfner M: Die stationäre Behandlung von Jugendlichen mit emotional bedingtem Schulabsentismus. Eine Kasuistik. *Verhaltenstherapie* 2008; 18: 177–184.
- e24. Ohmann S, Schuch B, Sackl P, Werneck-Rohrer S, Vesely C, Gössler R, Popow C: Kognitiv-verhaltenstherapeutische Gruppentherapie für Jugendliche mit angstbedingter Schulverweigerung. Eine Beobachtungsstudie. *Verhaltenstherapie* 2007; 17: 175–81.
- e25. Bernstein GA, Borchardt CM, Perwien AR: Imipramine plus cognitive behavioral therapy in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry* 2000; 39: 276–83.
- e26. King NJ, Tonge BJ, Heyne D, et al.: Cognitive-behavioral treatment of school refusing children: A controlled evaluation. *Journal of the American Academy of Child and Adolescent Psychiatry* 1998; 37: 395–403.
- e27. Heyne D, King NJ, Tonge BJ, Rollings S, Young D, Pritchard M, Ollendick T H: Evaluation of child therapy and caregiver training in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry* 2002; 41: 687–95.
- e28. Last PTT, Hansen C, Franco N: Cognitive-behavioral treatment of school phobia. *Journal of the American Academy of Child and Adolescent Psychiatry* 1998; 37: 404–11.
- e29. Kearney CA, Pursell C, Alvarez K: Treatment of school refusal behavior in children with mixed functional profiles. *Cognitive and Behavioral Practice* 2001; 8: 3–11.
- e30. Glaser A: Stationäre Behandlung von Jugendlichen mit Schulabsentismus: Konzept und Langzeiteffekte (Dissertation). Köln: Klinik und Poliklinik für Psychiatrie und Psychotherapie des Kindes- und Jugendalters 2009.
- e31. Overmeyer S, Blanz B, Schmidt MH, Rose F, Schmidbauer M: Schulverweigerung – eine katamnestic Untersuchung zu dem diagnostischen Konzept von „Schulphobie“ und „Schulangst“. *Zeitschrift für Kinder- und Jugendpsychiatrie* 1995; 23: 35–43.
- e32. Lehmkuhl G, Doll U: Das überängstliche Kind. Angstanfälle und Formen der Schulverweigerung, Therapie und Prognose. *Zeitschrift für Allgemeine Medizin*, 1994; 70: 278–83.
- e33. Bernstein GA, Hektner JM, Borchardt CM, McMillan MH: Treatment of school refusal: One-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry* 2001; 40: 206–13.
- e34. DJI.de (Homepage). Netzwerk Prävention von Schulmüdigkeit und Schulverweigerung. [www.dji.de/schulmuedigkeit](http://www.dji.de/schulmuedigkeit)